

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER

0046250 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,914	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,914	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			2,318	2,318	8
9	SNF/PED					9
10	ICF	17,055	4,692		21,747	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,055	4,692	2,318	24,065	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.23%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 03/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date _____ NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 79 and days of care provided 2,318

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **DOUGLAS REHABILITATION & CARE C** # **0046250** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	121,738	6,489	4,720	132,947		132,947		132,947			1
2	Food Purchase		91,369		91,369	(7,218)	84,151	(577)	83,574			2
3	Housekeeping	87,547	11,190		98,737		98,737		98,737			3
4	Laundry	25,720	6,382		32,102		32,102		32,102			4
5	Heat and Other Utilities			102,512	102,512		102,512	508	103,020			5
6	Maintenance	33,999	4,571	27,651	66,221		66,221	5,331	71,552			6
7	Other (specify):*			10,812	10,812		10,812		10,812			7
8	TOTAL General Services	269,004	120,001	145,695	534,700	(7,218)	527,482	5,262	532,744			8
	B. Health Care and Programs											
9	Medical Director			1,320	1,320		1,320		1,320			9
10	Nursing and Medical Records	1,049,119	64,525	21,083	1,134,727		1,134,727	1,673	1,136,400			10
10a	Therapy	15,069		186	15,255		15,255		15,255			10a
11	Activities	55,618	1,134		56,752		56,752		56,752			11
12	Social Services	29,474		5,100	34,574		34,574		34,574			12
13	Nurse Aide Training											13
14	Program Transportation			3,887	3,887		3,887		3,887			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,149,280	65,659	31,576	1,246,515		1,246,515	1,673	1,248,188			16
	C. General Administration											
17	Administrative	54,952		67,874	122,826		122,826	(34,420)	88,406			17
18	Directors Fees											18
19	Professional Services			80,447	80,447		80,447	(47,520)	32,927			19
20	Dues, Fees, Subscriptions & Promotions			12,138	12,138		12,138	(3,494)	8,644			20
21	Clerical & General Office Expenses	75,102	11,355	16,770	103,227		103,227	371	103,598			21
22	Employee Benefits & Payroll Taxes			233,243	233,243	7,218	240,461		240,461			22
23	Inservice Training & Education			2,034	2,034		2,034		2,034			23
24	Travel and Seminar			2,628	2,628		2,628	1,957	4,585			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,931	55,931		55,931	739	56,670			26
27	Other (specify):*			30,300	30,300		30,300	(16,422)	13,878			27
28	TOTAL General Administration	130,054	11,355	501,365	642,774	7,218	649,992	(98,789)	551,203			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,548,338	197,015	678,636	2,423,989		2,423,989	(91,854)	2,332,135			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	4,720
	REPAIRS & MAINTENANCE		0
			0
			4,720
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		43,406
	ELECTRICITY		28,394
	WATER		25,448
	CABLE TV - LOBBY		5,264
			0
			102,512
6	MAINTENANCE		
	GROUNDS MAINTENANCE		5,833
	PAINTING & DECORATING		0
	BUILDING REPAIRS		13,580
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		4,624
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		1,668
	FIRE SERVICE		1,946
			0
			0
			0
			27,651
7	OTHER		
	SCAVENGER		10,812
	SECURITY SERVICE		0
			10,812
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,320
			1,320

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		18,309
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,694
	PHARMACY CONSULTANT	XVIII B 39-2	1,080
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			21,083
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	186
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			186
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		82
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,018
	SOCIAL WORKER	XVIII B 45-2	0
			0
			5,100
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	3,887	3,887
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 67,874	67,874
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 6,452	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 73,995	
		0	80,447
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 3,736	
	EMPLOYEE WANT ADS	XIX F 1,356	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 4,371	
	LICENSES & PERMITS	XIX F 1,873	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 802	12,138
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,635	
	EQUIPMENT REPAIR & MAINTENANCE	3,178	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 312	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	11,645	
	MESSENGER SERVICE	0	
		0	16,770

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 117,513	
	UNEMPLOYMENT COMPENSATION	XIX D 25,998	
	WORKERS COMPENSATION INSURANCE	XIX D 72,444	
	HOSPITALIZATION INSURANCE	XIX D 14,560	
	EMPLOYEE BENEFITS - OTHER	XIX D 2,728	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	233,243
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	2,034	2,034
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 2,628	
		0	
		0	2,628
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	0	0
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	55,931	55,931
27	OTHER		
	BAD DEBTS	VI 24 30,300	
			30,300

GRAND TOTAL COLUMN 3 OTHER

678,636

DOUGLAS REHABILITATION & CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	91,369	PATIENT MEALS	72195
LESS SALES TAX	(577)	ADD EMPLOYEE MEALS	6222
	-----		-----
NET FOOD	90,792	TOTAL MEALS/YEAR	78417
TOTAL PATIENT CENSUS	24,065	NET FOOD	90792
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	78417

TOTAL PATIENT MEALS	72195	COST PER MEAL	1.16
		TIME EMPLOYEE MEALS	6222
ADD # EMPLOYEE MEALS/DAY	17		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	7218
	-----		=====
TOTAL EMPLOYEE MEALS	6222		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,379	4,379		4,379	(3,883)	496			30
31	Amortization of Pre-Op. & Org.			1,400	1,400		1,400		1,400			31
32	Interest			30,151	30,151		30,151	(674)	29,477			32
33	Real Estate Taxes			37,254	37,254		37,254		37,254			33
34	Rent-Facility & Grounds			346,020	346,020		346,020		346,020			34
35	Rent-Equipment & Vehicles			17,144	17,144		17,144		17,144			35
36	Other (specify):* amort software			7,715	7,715		7,715		7,715			36
37	TOTAL Ownership			444,063	444,063		444,063	(4,557)	439,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,548	207,394	287,942		287,942		287,942			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,372	43,372		43,372		43,372			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		80,548	250,766	331,314		331,314		331,314			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,548,338	277,563	1,373,465	3,199,366		3,199,366	(96,411)	3,102,955			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,883)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(577)	2		13
14	Non-Care Related Interest	(674)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(312)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,300)	27		24
25	Fund Raising, Advertising and Promotional	(3,736)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(74,877)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,359)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	17,948		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17,948		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (96,411)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
DOUGLAS REHABILITATION & CARE CENTER

Page 5A

ID# 0046250
Report Period Beginning: 01/01/2004
Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	BANK CHARGES	(1,635)	21	2
3	MARKETING CONSULTANT	(12,000)	19	3
4	DATA PROCESSING-HEALTHCARE HORIZONS	(8,250)	19	4
5	MARKETING SALARY	(23,142)	21	5
6	MARKETING TRAVEL	(1,015)	24	6
7	PROFESSIONAL FEES ELITE CARE CORP	(28,835)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(74,877)		49

Summary A

12/31/2004

[illegible]

Summary B

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				HI CARE		
				MANAGEMENT	SPRINGFIELD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 67,874	HI CARE MANAGEMENT		\$	(67,874)	1
2	V	5	UTILITIES				508	508	2
3	V	6	MAINTENANCE				5,331	5,331	3
4	V								4
5	V	10	NURSING CONSULTANT				1,673	1,673	5
6	V	17	OFFICER SALARY				33,454	33,454	6
7	V	19	PROFESSIONAL FEES				1,565	1,565	7
8	V	20	DUES & SUBSCRIPTIONS				242	242	8
9	V	21	OFFICE EXPENSE				25,460	25,460	9
10	V								10
11	V	24	TRAVEL				2,972	2,972	11
12	V	26	INSURANCE				739	739	12
13	V	27	PAYROLL TAXES & GRP INS				13,878	13,878	13
14	Total			\$ 67,874			\$ 85,822	\$ * 17,948	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DOUGLAS REHABILITATION & CARE C # 0046250 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.					SALARY	\$ 17,380	17-8	1
2	TOTAL SALARY RECEIVED FROM HI CARE \$108,216										2
3											3
4											4
5	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.					SALARY	16,074	17-8	5
6	TOTAL SALARY RECEIVED FROM HI CARE \$100,089										6
7											7
8											8
9											9
10	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING					SALARY	1,072	21-8	10
11	TOTAL SALARY RECEIVED FROM HI CARE \$6672										11
12											12
13								TOTAL	\$ 34,526		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DOUGLAS REHABILITATION & CARE CENTER # 0046250 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HI CARE MANAGEMENT
Street Address 827 S FIFTH STREET
City / State / Zip Code SPRINGFIELD, IL. 62703
Phone Number (217)528-0044
Fax Number (217)528-3412

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	149,844	6	\$ 3,165	\$	24,065	\$ 508	1
2	6	MAINTENANCE	PER RESIDENT DAY	149,844	6	33,197	32,571	24,065	5,331	2
3										3
4	10	NURSING CONSULTANT	PER RESIDENT DAY	149,844	6	10,417	10,417	24,065	1,673	4
5	17	OFFICER SALARY	PER RESIDENT DAY	149,844	6	208,305	208,305	24,065	33,454	5
6	19	PROFESSIONAL FEES	PER RESIDENT DAY	149,844	6	9,744		24,065	1,565	6
7	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	149,844	6	1,504		24,065	242	7
8	21	OFFICE EXPENSE	PER RESIDENT DAY	149,844	6	158,533	120,987	24,065	25,460	8
9										9
10	24	TRAVEL & EDUCATION	PER RESIDENT DAY	149,844	6	18,505		24,065	2,972	10
11	26	INSURANCE	PER RESIDENT DAY	149,844	6	4,600		24,065	739	11
12	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	149,844	6	86,416		24,065	13,878	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 534,386	\$ 372,280		\$ 85,822	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5	MEMBERS LOAN						100,000	100,000				7,234	5
	Working Capital												
6	ILLINI BANK		X	LINE OF CREDIT	INTEREST	REVOLV		233,597				16,618	6
7	ILLINI BANK		X	WORKING CAPITAL	1580 + INT	9/25/03	75,000	59,394	9/25/08	0.0964		6,299	7
8													8
9	TOTAL Facility Related						\$ 175,000	\$ 392,991				\$ 30,151	9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 175,000	\$ 392,991				\$ 30,151	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.			\$	29,445	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	30,417	2
3. Under or (over) accrual (line 2 minus line 1).			\$	972	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,282	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	37,254	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999		8	
		2000		9	
		2001		10	
		2002	35,123	11	
		2003	30,417	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

DOUGLAS REHABILITATION & CARE CENTER

COUNTY

COLES

FACILITY IDPH LICENSE NUMBER

0046250

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	07-1-00300-000	NURSING HOME	\$ 33,869.04	\$ 33,869.04
2.	07-1-00300-001	NURSING HOME	\$ 2,044.48	\$ 2,044.48
3.	07-1-00572-000	NURSING HOME	\$ 368.76	\$ 368.76
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 36,282.28	\$ 36,282.28

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

7,000

2. Number of Years Over Which it is Being Amortized:

5

3. Current Period Amortization:

1,400

4. Dates Incurred:

3/01/03

Nature of Costs: LEGAL COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSULATION			2004	10,441	143	27.5	143		143	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,441	\$ 143		\$ 143	\$	\$ 143	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	7,060	4,236	353	(3,883)	10 YRS	353	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 7,060	\$ 4,236	\$ 353	\$ (3,883)		\$ 353	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,501	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,379	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 496	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,883)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 496	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELITE MATTOON, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		79	2/28/03	\$ 346,020	10		3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 346,020			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 17,144
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 3/1/03

Ending 2/28/13

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$ 346,020
13.	/2006	\$ 346,020
14.	/2007	\$ 346,020

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 71,226	\$		\$ 71,226	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			22,100			22,100	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			114,068			114,068	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				80,548		80,548	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 207,394	\$ 80,548		\$ 287,942	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,103	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (30,000))	542,037		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,491		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	20,000		8
9	Other(specify): Real Estate Escrow Deposit	27,943		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 658,574	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	10,441		15
16	Equipment, at Historical Cost	30,205		16
17	Accumulated Depreciation (book methods)	(18,523)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,567)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 685,130	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 315,910	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	292,991		29
30	Accrued Salaries Payable	53,605		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,499		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,282		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 723,287	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 823,287	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (138,157)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 685,130	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (68,820)	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(17,453)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (86,273)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(50,884)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (51,884)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (138,157)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,012,393	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,012,393	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	127,247	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 127,247	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	674	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 674	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RENTAL INCOME	8,168	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,168	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,148,482	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	534,700	31
32	Health Care	1,246,515	32
33	General Administration	642,774	33
	B. Capital Expense		
34	Ownership	444,063	34
	C. Ancillary Expense		
35	Special Cost Centers	287,942	35
36	Provider Participation Fee	43,372	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,199,366	40
41	Income before Income Taxes (line 30 minus line 40)**	(50,884)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (50,884)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,975	2,083	\$ 54,029	\$ 25.94	1
2	Assistant Director of Nursing	2,408	2,505	55,086	21.99	2
3	Registered Nurses	2,383	2,439	45,156	18.51	3
4	Licensed Practical Nurses	19,353	19,896	293,166	14.73	4
5	Nurse Aides & Orderlies	50,449	51,631	531,212	10.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,413	1,466	15,069	10.28	8
9	Activity Director	2,067	2,116	19,494	9.21	9
10	Activity Assistants	1,764	1,795	12,743	7.10	10
11	Social Service Workers	2,010	2,058	29,474	14.32	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,085	28,747	13.79	13
14	Head Cook	7,321	7,574	60,361	7.97	14
15	Cook Helpers/Assistants	4,526	4,639	32,630	7.03	15
16	Dishwashers					16
17	Maintenance Workers	2,363	2,470	33,999	13.76	17
18	Housekeepers	10,484	10,785	87,547	8.12	18
19	Laundry	3,538	3,609	25,720	7.13	19
20	Administrator	1,901	2,091	54,952	26.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,035	2,083	34,619	16.62	23
24	Clerical	2,045	2,093	17,341	8.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	862	862	8,542	9.91	31
32	Other Health Care: <u>MDS careplan</u>	3,231	3,327	56,462	16.97	32
33	Other(specify) _____	4,048	4,135	51,989	12.57	33
34	TOTAL (lines 1 - 33)	128,213	131,742	\$ 1,548,338 *	\$ 11.75	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,720	1-3	35
36	Medical Director	O	1,320	9-3	36
37	Medical Records Consultant	N	1,694	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,080	10-3	39
40	Physical Therapy Consultant	L	186	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	5,018	12-3	45
46	Other(specify) _____	S			46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)		\$ 14,018		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
	ADMIN		\$ 54,952	Workers' Compensation Insurance	\$	72,444	IDPH License Fee	\$ 1,027
DIANNA SPENCE	ASST ADMIN	0	0	Unemployment Compensation Insurance		25,998	Advertising: Employee Recruitment	1,356
				FICA Taxes		117,513	Health Care Worker Background Check	802
				Employee Health Insurance		14,560	(Indicate # of checks performed)	
				Employee Meals		7,218	MARKETING/ADV/PROMO	3,736
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	0
				EMPLOYEE BENEFITS - OTHER		2,728	LICENSES & PERMITS	846
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	4,371
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	242
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 54,952	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	0
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other							Non-allowable advertising	(3,736)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising	(0)
HI CARE MANAGEMENT			\$ 67,874					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 67,874	TOTAL (agree to Schedule V,	\$	240,461	TOTAL (agree to Sch. V,	\$ 8,644
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ACHIEVE SOFTWARE	DATA PROCESSING		\$ 5,819			\$	Out-of-State Travel	\$
BRIGGS CORPORATION			75					
IVANS	DATA PROCESSING		558					
KRUPNICK BOKOR	ACCOUNTING		18,050				In-State Travel	
RICHARD PEELO	MEDICARE CONSULTANT		3,000					2,628
STRATTON GIGANTIST	LEGAL		2,866				DISALLOW TRAVEL	(1,015)
ELITE CARE CORPORATION	ENVIRONMENTAL CONSLT		28,835				MGMT CO ALLOC	2,972
HEALTHCARE HORIZONS			8,250				Seminar Expense	
HICARE MANAGEMENT			12,000					0
PERSONNEL PLANNER	UNEMPLOYMENT CONSLT		994					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 80,447	TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)							(agree to Sch. V,	
							line 24, col. 8)	\$ 4,585

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC \$3,859
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,474 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 43,372
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 7,218 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees